State of Maine Department of Human Services

Application for Health Insurance

MaineCare for Families with Children and Pregnant Women

Return to:	
REC'D	45TH DAY

1. Person Filling Out The Application

Name (first, middle initial, last)		
Social Security Number	**Birthdate** (month/day/year)	**Sex**

Check one ◯ **married** ◯ **widowed** ◯ **single** ◯ **divorced** ◯ **separated**

2. Mailing Address

Street, PO Box or RR (include apartment number, in care of, etc.)

City:	**State:**	**Zip code:**	**Home phone:**	**Work phone:**

If different from your mailing address, write in the address where you actually live:

3. Household Members *List the people who live with you*

Last name	First name	Middle initial	Sex	Date of birth	Social Security Number	Relationship to you

Is anyone in your household applying due to pregnancy? ◯ **Yes** ◯ **No**

Name: **Due date:**

4. Household Earnings *Attach paystubs or photocopies of paystubs for the last 4 weeks*

Name	Employer's name and phone	Amount you earn	How often you are paid	Hours worked each week

5. Self-Employment *Attach a copy of your most recent tax return including all schedules*

Name of person who is self-employed	**If you did not file a tax return. check here** ◯
Name of business	**Hours worked weekly**

6. Unearned Income *Attach proof of income listed below, except for Social Security or SSI*

Name of person receiving income	Where is income from? (Social Security, Unemployment, etc.)	How often received? (monthly, weekly, etc.)	Amount before deductions

7. Child Care Expenses *(Paid by a member of your household)*

Name of child care provider	Child's name	Amount paid	How often paid? (monthly, weekly, etc.)

8. Child Support *(Paid by a member of your household)*

Name of person who pays support	Person to whom support is paid	Amount paid	How often paid? (monthly, weekly, etc.)

9. Health Insurance

List children in your household who now <u>have</u> health insurance (except for MaineCare) which covers more than one service:

_____

List children in your household who <u>lost</u> health insurance (except for MaineCare) in the last 3 months and why they lost insurance:

_____

List children in your household who can be added to a household member's State employee health insurance:

10. Special Conditions

◯ **Check here if anyone has a disabling condition or is applying for HIV/AIDS Benefits.** *(There may be special help available to you.)*

◯ **Check here if your child is a member of a Federally recognized American Indian tribe or an Alaskan Native.** *(No premium is required.)* **Name of tribe** _____

Is everyone for whom you are applying a U.S. citizen? ◯ **Yes** ◯ **No**

If English is not your first language, what language do you speak? _____

Are you asking for help with medical bills incurred in the last 3 months? ◯ **Yes** ◯ **No**

Do you want to apply for Food Stamps? ◯ **Yes** ◯ **No**

11. Assets *Complete only if you are applying for yourself along with your children and teens age 18 and under.*

a. Cashable Assets

Type of asset	Name(s) on account	Account number and bank	Value or balance

b. Real Estate (other than the home where you live)

Owners	Type of real estate

c. Vehicles

Year	Make/model	Owner(s)	Current value	Amount owed

12. Signature

If you have to pay a premium, coverage can start either the month the Dept. of Human Services receives this application, or the next month. Please write the name of the month you want coverage to start. _____

Social Security numbers are used to do computer matches with the IRS, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. The Department of Human Services and federal officials may check with other persons/organizations to prove the information you give. I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know. I understand the Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the MaineCare card was used.

_____

Signature of person filling out this form **Date**